Healthy RI National Health Reform Implementation Taskforce

Payment Reform/Delivery System and Providers Work Group

Notes from 07/09/10 Meeting

1. Focus of the Work Group

   It was suggested that the Work Group should focus on reimbursement reform in order to achieve delivery system reform. However, it was noted that while there are payment directives in the federal health reform statute, most of those directives address insurance market reform rather than precisely payment realignment. There are also payment rate changes for Medicare and Medicaid in the federal health reform. However, those payment rate changes are mandated by law and implemented by Medicare and Medicaid, so the state has no option but to comply with those mandates. The Work Group can, however, look at Medicare and Medicaid payment reform in the federal law and discuss whether the state would want to use those reforms as a template for wider payment realignment.

   The Work Group concluded, however, that its discussion should instead focus on the decisions and opportunities available to Rhode Island in the federal health reform. Rather than creating a completely new health care system, the state needs to build upon the existing infrastructure in the state, and Rhode Island already has many strong models upon which to build.

2. It is important to note that the allocated funds from the federal health reform must be obligated by September 30th. Hence, solicitations for pilots/grants are coming out quickly now and will continue to do so until September 30th.

3. Current RI efforts relevant to payment realignment

   After briefly reviewing the list of current RI efforts relevant to payment realignment, the Work Group suggested that the following programs/initiatives be added to the list:

   - PACE
   - OHIC health plan rate approval conditions re hospital contracts
   - Payment restructuring in Article 20 of the 2011 Budget Act
   - Medical error reporting system
   - BCBSRI application for implementation of high risk pool in Rhode Island
   - South County hospital's medical neighborhood

   After reviewing the list of current RI effort relevant to payment realignment, the Work Group agreed that there may be a delivery system reform opportunity in Chronic Care Sustainability Initiative (CSI) with the Medicare Multipayer Demonstration Grant. The federal government will award grants to six states to set up Medicare medical home demonstrations. There is, however, stiff competition for the grant, because only 6 grants are available and there are 9 very well developed medical home models across the country.

CSI qualifies for the Medicare Multipayer Demonstration and is applying for the grant, which is due in mid-August. If CSI is successful, Medicare would be added to the current practices in CSI and Medicare would pay the same amount to CSI as do other insurers. Currently Medicare makes up about 1/3 of the participants in CSI, but the grant would add another 20,000 patients to CSI. CSI is a good candidate for this grant because it is a non-integrated model that is easier to replicate than models such as Geisinger and the Mayo Clinic.

4. American Hospital Association's Legislative Advisory: Summary of 2010 Health Care Reform Legislation, specifically section titled "Key Delivery System Reforms"

While every state and non-profit agency is tracking health reform, the availability of information regarding the many efforts and pilots/grants vary greatly. Many efforts and pilots/grants are being communicated in some detail, but many are coming out as just the text of the statute with no accompanying details. One of the documents contributed to the Work Group, the American Hospital Association's April 19th Legislative Advisory summarizing the 2010 Health Care Reform Legislation, and specifically the section titled "Key Delivery System Reforms," is a good summary of the payment and delivery system reforms proposed by the federal statute.

Although the section is titled "Key Delivery System Reforms," the reforms would in fact affect payment reforms. Rather than being a misnomer, however, the title of the section actually reflects the reality that payment reform (realignment) and delivery system reform must go together. Delivery system reform cannot be accomplished without the payment reforms (realignment) that underlie it.

a. Hospital Value-Based Purchasing (VBP)

Under hospital value-based purchasing (VBP), hospitals submit quality reports to the Center for Medicare and Medicaid Services (CMS) and receive discounts for good quality care and penalties for bad quality care. This reform is budget neutral, so the penalties will pay for the discounts and will essentially be a redistribution of payments.

VBP will particularly affect Medicare services. It will probably be initiated in a demonstration for period of time, after which the federal government will decide how to roll out reforms to the rest of the Medicare program.

However, it was mentioned that one of the problems with VBP is its failure to keep up with current medical science, because the core measures are usually 1 or 2 years behind science.

The Work Group decided that this initiative is one to watch but one in which no action can be taken at this moment.

b. National Pilot Program on Payment Bundling

The National Pilot Program on Payment Bundling is a Medicare effort that is similar to creating an accountable care organization (ACO). A bundled payment is a payment for an episode of care, which covers the initial hospital stay and all associated services, as opposed to fee-for-service, which is a payment for a specific

procedure or service. As such, this is a demonstration that represents an attempt to move away from the fragmentation of the fee-for-service model. There was concern, however, that the bulk of the population would resist a shift from fee-for-service model into a bundled payment model.

Furthermore, this payment model has implications for free standing health care providers, such as imaging centers and rehabilitation centers, and it is unclear how health care providers outside of the hospital would be paid under this model. Small business, entrepreneurial physicians, in particular, may not survive under this bundled payment model and may be absorbed into the system. With the understanding that the majority of the marketplace will remain fee-for-service, however, it was suggested that small business, entrepreneurial physicians will be able to subsist off the majority of the marketplace that will continue to operate under the fee-for-service model.

The Work Group also argued that hospitals cannot be the apex of the bundled payment ventures and that, rather, these ventures must be physician-led and physician-centered. Providers rather the legislation will drive bundled payment initiatives, because if the model demonstrates cost effectiveness and quality improvements, then the market will naturally move towards the bundled payment model. The Work Group also suggested that in order for efficient payment administration, practices accepting bundled payments must be fully integrated, joint venture operations. Division of payments can become an issue because there is no clear way under the demonstration to divide up the one bundled payment among different care providers.

5. Additional discussions

a. Other models and opportunities

The Work Group agreed that in addition to monitoring the pilots/demonstration opportunities arising out of the federal reform, Rhode Island should also track pilots/demonstrations being implemented in other states around the country as well.

Also, it was noted that another bundled model for Medicaid will be implemented January 2012, and it was suggested that Rhode Island should be aware of the upcoming solicitation.

Furthermore, HHS recently released draft regulations pertaining to delivery system and payment reform that is open for comment. The interns will distribute the link to the Work Group for the convenience of all who are interested.

b. Avoiding fractionalization and pursuing multi-payer efforts

Many of the pilots/demonstrations and grants available in the federal statute, however, are fractionized based on payer, especially between Medicare and Medicaid. An issue of importance, therefore, is whether Rhode Island should pursue payer-specific opportunities or multi-payer opportunities. Although the Work Group generally supports the idea of an integrated and consistent payment system,

it decided that Rhode Island should pay attention to both kinds of opportunities so as to not exclude any possibilities. The Work Group would recommend, however, that, as the state considers Medicare/Medicaid demonstrations, the demonstrations be considered as models with the potential to be expanded and implemented in a way that allows for and encourages other payers to participate.

c. Fate and impact of the self-insured

The Work Group was concerned that the self-insured may choose to desist from participating in the reform effort. It was argued, however, that if reform efforts are successful, then the self-insured would want to participate. In order for the self-insured to know of the success of health care reform, however, there must ways for demonstrations and programs to measure success and to communicate those successes to the public.

d. Pediatrics in health care reform

The Work Group also recognized that, while pediatrics is ahead of the curve in delivery of care, pediatric care must be part of the reform discussion in order to ensure that pediatrics does not fall behind the new curve and that health reform takes full advantage of the prevention opportunities available in early life care.

Members in Attendance

Tricia Leddy

Jia Leung

Joan Moses

Ted Almon

Charlie Kinney

Deborah Correia Morales

B.J. Perry

George Babcock

Jenny Hayhurst

Craig O'Connor

Robin Benoit

Steve DeToy

Rebecca Kislak

Mike Souza

Howard Dulude

Rick Brooks

Elaina Goldstein

Diane Ferreira

Vera DePalo

Jason Martiesian

Nick Tsiongas

Robert Kalaskowski

Mark Schwager

Lenny Lopes

Beth Lange